

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032789
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registered District No. 318
FILED AUG 5 1962

Primary Registration District No.

Registrar's No.

8165

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY FRANKLIN	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN UNION	
c. FULL NAME OF HOSPITAL OR INSTITUTION DEACONESS HOSPITAL		d. STREET ADDRESS (If outside, give location) 2 W. SPRINGFIELD AVT	
3. NAME OF DECEASED (Type or print) First LOUIS Middle F. Last PFEIFFER		4. DATE OF DEATH Month AUGUST Day 21 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH JULY 2, 1875 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY CARPENTER	11. BIRTHPLACE (City and state or country) BEAUFORT, MO.
13a. FATHER'S NAME GEORGE PFEIFFER		13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE LENA PFEIFFER DEC.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cause of Colon Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. Cerebral thrombosis DUE TO (b) 153.8 DUE TO (c)		17. INFORMANT Address GILMORE PFEIFFER KOELLING AVE. UNION, MO.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from 8/14/62 to 8/21/62 and last saw her alive on 8/20/62		Death occurred at 10 AM m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Grace Sells M.D.	22b. ADDRESS 7820 Carondelet	22c. DATE SIGNED 8/22/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE AUG. 24, 1962	23c. NAME OF CEMETERY OR CREMATORY ZION EVGAN. CEMETERY	23d. LOCATION (City, town, or county) UNION MO.
24. FUNERAL DIRECTOR ADDRESS OLTMANN FUNERAL HOME UNION, MO.		25. DATE RECD. BY LOCAL REG. AUG 22 1962	26. REGISTRAR'S SIGNATURE Earl Smith. M.D.

USE BLACK INK

OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Ernst L. Oldmann

Licensed Embalmer No. _____

4054

P. O. Address _____

Union, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.